# HB 4851 a physician response

Thank you for the opportunity to comment on House Bill 4851.

In the MMMA, the recommendation for the use of medical marijuana is made in the setting of a 'bona fide' doctor patient relationship. The problem with the Act is that it does not actually define the term 'bona fide' because it is assumed everyone already knows what it is. Everyone does know what it is, the problem is that not everyone has the same understanding, or applies it based on desired outcome, without considering the appropriateness of the setting. Others exploit the lack of a formal definition for financial gain, or to ease prosecution of people they view as engaging in criminal activity by negating the protections of the MMMA.

While the proposed house bill 4851 does attempt to define the term 'bona fide' it does so in a rather rigid way without an understanding of the practice of medicine.

The definition of 'bona fide' used in my practice for medical marijuana certification is flexible, protects the integrity of the certification, is legally defensible, and is not overly restrictive while following good medical practice....

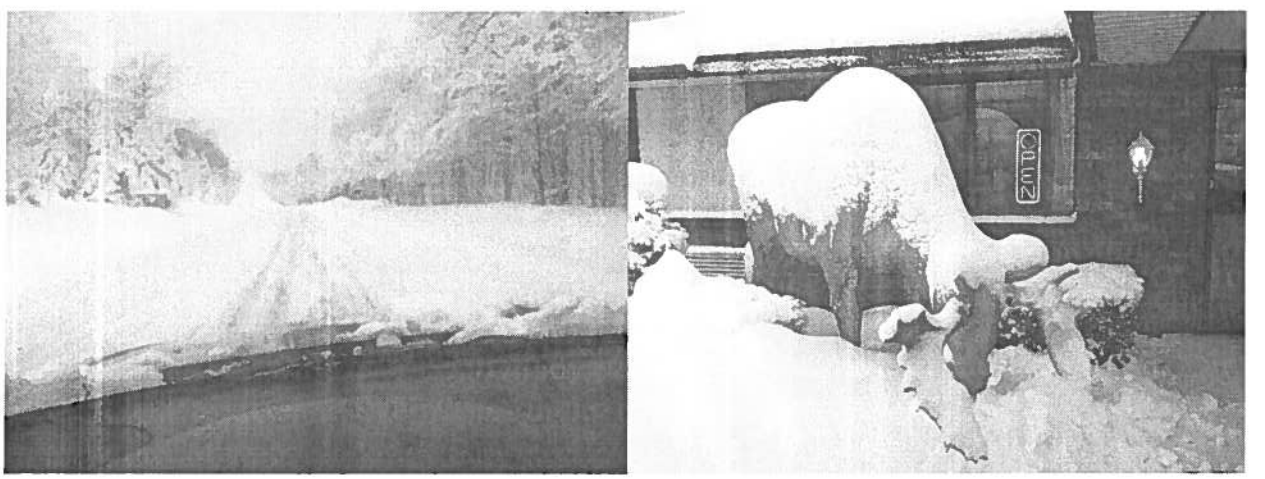
1. There will be real time interaction between the physician and patient, either in person or via telemedicine in appropriate settings. During this interview, prior experience with marijuana, prior traditional medical treatments, and expectations from medical marijuana are explored. There is a discussion of the advantages, disadvantages, and the experience of patients with similar conditions.
2. If there are medical records supporting the qualifying diagnosis to a degree of medical certainty, the certification is issued.
3. If there are NOT medical records available, the patient is treated as having a new condition requiring full work up to establish the medical record to support the diagnosis to a degree of medical certainty. Self-reported symptoms in the absence of diagnostic testing, serial exams, etc. are NOT acceptable.
4. Follow up is strongly recommended (and offered free of charge) approximately ½ way through the course of treatment. The physician is readily available by phone, teleconference, and in person for follow up, questions, or problems (medical or legal) at any time free of charge.
5. To avoid the confusion surrounding undefined terms, the term 'degree of medical certainty' is defined as a diagnosis based on objective data (chart notes, testing, exams) which follows generally accepted medical practice and is able to withstand peer review.

The basis of these 'best practice' guidelines used by my practice is to provide certifications that will stand up to medical and legal review, follow the spirit of the MMMA, and good medical practice. Good medical practice has been recently defined by the medical board. Unlike legislation, the guidelines of the medical board are written by medical professionals for medical professionals. Justification for deviation from the guidelines when it is the best interest of the patient can be offered, and the judgment of a competent physician carries weight.

The recommendation for medical marijuana is generally more of a consult than an actual diagnostic visit. In most cases, patients have a primary care physician that has reached and documented a diagnosis, the decision to recommend medical marijuana based on the established diagnosis is a consult and an opinion by a specialist.

The need for this specialist consultation arises because most primary care doctors are NOT ALLOWED by their employers to write certifications. This later statement is supported by the report of the Michigan Medical Marihuana Program in April, 2011, which showed only 1 in 15 Michigan doctors have ever written a single certification, and that 70% are written by one of 55 physicians that devote much of their practices to cannabis medicine.

Many patients are in fact afraid to discuss their interest in medical marijuana with their primary doctors for fear of having their pain medication cut off or being dismissed from the practice due to 'office policy' or because the practice has 'federal funding'. There are no protections for patients (or employed physicians for that matter) against dismissal or other adverse action associated with the use or recommendation of medical marijuana.



Please note the amount of snowfall and driving conditions during my clinics in the UP this last weekend. These clinics were scheduled weeks in advance and were the only times I could bring live certification clinics to the UP. There are VERY few opportunities for certification under the new medical board guidelines in the UP other than my clinics in Houghton, Marquette, Munising, and Escanaba/Iron Mountain.

This last weekend it took more than 6 hours, through a blizzard sporting 20 inches of snowfall and 40 mph winds, to reach the bridge from Mt. Pleasant. It took a further 6 hours in white out conditions to reach Marquette from the bridge. Patients had to drive up to 5 hours to reach one of the 4 clinics I held, and over 20 had to cancel due to the adverse weather. Many of them were over the age of 50, with clear conditions like crohn's, cancer, glaucoma, and well documented chronic pain. Many had come off narcotics thanks to medical marijuana.

Yet because the proposed HB 4851 mandated an in person, hands on visit with the doctor, these people risked their lives to reach the clinic in those weather conditions, not to mention the doctor driving more than 20 hours to reach them. Here is another shot of the weather. This is MY VEHICLE parked in front of a clinic for 4 hours.... Note the amount of ice caked in the grill and the drifting....

Telemedicine has been used for years in medicine. As a practicing Internist and part time ER doctor, in practice for nearly 20 years without a malpractice case, I've used telemedicine since the mid 1990's. We used 'night hawk' telemedicine services with radiologists in Oregon and New Zealand reading our CT scans at night. In Alaska we used extensive telemedicine to evaluate patients in the rural villages. The VA used telemedicine for psychiatry, and the U of M uses it to bring specialty care to remote areas (like the UP). Prisoners are arraigned from jail via teleconference, disability hearings for Social Security are held by teleconference, and so are many business meetings. Telemedicine (which involves a face to face video meeting, not just a phone call or an on line form that is filled out by a patient and rubber stamped by a physician or pharmacist) has been a part of medicine for over 15 years and will continue to grow in the 21st century. Rather than attempt to repress it, the goal of the legislature should be to regulate telemedicine.

In the case of medical marijuana certification, for the most part we are dealing with an established diagnosis. Under the MMMA, and in the guidelines from the medical board, an 'appropriate' physical exam is recommended. This is used as a basis for a proposed prohibition of telemedicine, as the ability of the physician to 'physically examine' a patient is limited. Yes, there are devices that would allow me to look in your ear and listen to your heart via telemedicine. But consider the following...

For chronic severe pain, what is the appropriate physical exam? What physical finding confirms or denies the diagnosis of chronic pain? Does a scar on a back mean the patient has chronic pain? The purpose of the laminectomy reported in the medical records was to relieve the pain. Does the lack of a scar mean the patient has no chronic back pain? Or is the diagnosis made by the medical record confirming the use of pain medication, chiropractic care, physical therapy and epidural injections, supported by x-rays and CT scans?

For cancer, are we dealing with an unknown lump that requires biopsy, or a known diagnosis of small cell lung cancer in the middle of scheduled chemotherapy? Does feeling the lump make the diagnosis or do the records the patient brings to the clinic and hands or faxes to the physician?

What is the physical finding the physician needs to diagnosis crohn's disease at the clinic? Or does reviewing the notes of the primary care doctor, the colonoscopy report, the pathology of the biopsy confirm the qualifying condition?

The patients in my practice have an average age of over 50. They, without exceptions, have medical records on file with me supporting their certification. I follow them up, and have always followed the guidelines recently released by the medical board. The ONLY change made is that rather than see those cancer, glaucoma, crohn's, and chronic pain patients in the Western UP in person, forcing them (and me) to drive through dangerous conditions in the middle of a blizzard, I would have seen them in better weather and safer conditions via

telemedicine. The same records I drove 20 hours through the snow to review last weekend, I would have reviewed in my office and put in their charts. They would have been safer, I would have been safer, and access to quality certification would have been promoted.

Lack of telemedicine restricted that access to 20 patients who could not get to the clinics due to the weather and missed their renewals or new certifications until next month when I return. The only reason telemedicine was restricted in the setting of medical marijuana is lack of understanding of the prevalence of telemedicine in general practice (and law, business, and other fields). Equating telemedicine with a phone call, or filling out an on line form, is another common misconception.

The final issue I would like to address is the requirement for some sort of 'traditional fixed medical setting' where follow up could be offered for certification. When I was in the army, I took care of patients in tents. At Lansing Mercy Ambulance as a paramedic, I ran codes on cardiac arrest victims in the back of an Econoline 350 van. It is not where you care for patients, it is how you do it that counts. My practice has always met the standards issued by the board and continues to do so. I have fixed based offices in Mt. Pleasant, Saginaw, Cadillac, Traverse City, and Marquette. I do outreach clinics at compassion clubs, hotel conference rooms, and county airport terminals (I fly in to some of my more remote and distant clinics). Regardless of the physical setting, I use the same standards wherever I see patients.

# Recommendations:

*Prior to making ANY recommendations to change the process of certification, ask several questions...*

1. How does the change promote access to certification for qualified patients? How does it assure a legitimate patient with a qualifying condition can obtain a certification?
2. How does the proposed change protect the integrity of the certification process? Is it held to the same (rather than a higher) standard as a pain clinic or other primary care practice? What role does it leave to the medical board?
3. What flexibility does the proposed change allow a competent physician to best care for an individual patient with special needs? Consider homebound patients, patients in remote locations, weather, and urgency to meet the renewal deadlines, etc.
4. How does the proposed change allow a qualified patient to meet the standards to qualify for the card?
5. Does the proposed bill promote access to certification or prosecution of the patient?

Please consider the following:

Use of my 5 point definition of 'bona fide' will not overly restrict or micromanage the certification process, while allowing physician judgment and the ability to justify individual

physician actions in specific patient settings- the traditional approach to the regulation of medicine via the professional board.

Signature mills, selling certifications based on 'affidavits' or spot decisions of questionable medical judgment (you 'look' like you have crohn's disease or chronic pain, so here you go...), no record clinics, presigned certifications, or certifications by telephone, mail, or on line forms will not stand up to the 5 point definition.

Base the legitimacy of the certification on the medical decision making process, not the setting.

Consider the needs of rural communities in remote parts of the state which cannot support a full time, local certification clinic and where local physicians may be barred from writing certifications due to employer policy. Do you expect everyone in the state to drive to Detroit or Grand Rapids to get a certification from a full time certification clinic that derives less than 50% of their business from certifications? Does that promote access to certification as the voters anticipated?

Consider promoting the participation of primary care doctors as a way of reducing the need for certification clinics. Primary care doctors want a standard to follow to protect their licenses. They need the comfort of knowing what is expected of them and are now getting that from the board. Their main need now is protection against the unjustified restrictions placed on their practices by their employers.

Consider issuing a special 'rider' or 'endorsement' for telemedicine through the medical board. In order to practice telemedicine in Michigan, require not only a medical license, but demonstration of experience or specialty training in telemedicine (like a 6 hour CME course outlining 'best practices', legal considerations, and technology).

Telemedicine could simply be specifically allowed in the Bill, with restrictions to prevent abuse:

1. Physical residence in the State of Michigan of the telemedicine physician
2. Professional qualifications above the 'valid medical license' required by the MMMA
    a. Valid DEA registration
    b. No history of Board Discipline
    c. Demonstrated experience with telemedicine
3. Telemedicine could only be offered at sites where the physician physically conducts live clinics at periodic intervals- monthly to quarterly for example.
4. A licensed health care professional must be present with the patient during the video conference.
5. Written justification for the telemed rather than a live visit must be documented in the chart.

Respectfully submitted-

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